



| SECONDARY (MOONLIGHTING) JOBS YOU HAVE HELD <i>(Firefighter, farmer, etc.)</i>                                   |                          |                          |                          | DATES (MO/YR)  |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| JOB TITLE  | FROM                     | TO                       |                          |  |                          |                          |                          |
|  |                          |                          |                          |  |                          |                          |                          |
| HOBBIES & ACTIVE SPORTS <i>(Past and present, such as painting, woodworking, scuba diving, etc.)</i>             |                          |                          |                          |  |                          |                          |                          |
|  |                          |                          |                          |  |                          |                          |                          |
| WORK RELATED EXPERIENCES, COMMENT ON <i>(Those you feel may have been harmful to your health)</i>                |                          |                          |                          |  |                          |                          |                          |
|  |                          |                          |                          |  |                          |                          |                          |
| <b>PART II - RESPIRATORY SYMPTOMS</b>  |                          |                          |                          |  |                          |                          |                          |
| Since your last examination or visit to the doctor, have you experienced any of the following?                   |                          |                          |                          |  |                          |                          |                          |
| SYMPTOM  | YES                      | NO                       | NOT SURE                 | SYMPTOM  | YES                      | NO                       | NOT SURE                 |
| a. COUGH   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | h. EXPECTORATION (PHLEGM)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. FEVER   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | i. STUFFY NOSE   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. CHILLS  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | j. EYES BURNING OR WATERING  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. MUSCLE ACHES  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | k. THROAT SORE OR BURNING  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. SHORTNESS OF BREATH   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | l. LOSS OF APPETITE  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. CHEST PAINS, ACHING, TIGHTNESS, BURNING   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | m. WEIGHT LOSS   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. WHEEZING  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU SMOKE CIGARETTES, CIGARS OR PIPE  | <input type="checkbox"/> | <input type="checkbox"/> |                          | HOW OLD WERE YOU WHEN YOU BEGAN TO SMOKE CIGARETTES, CIGARS OR PIPE? |                          |                          |                          |
| NUMBER OF CIGARETTES, CIGARS OR PIPEFULS SMOKED DAILY. GIVE BEST ESTIMATE <i>(A pack contains 20 cigarettes)</i> |                          |                          |                          |  |                          |                          |                          |
| _____ CIGARETTES/DAY   | _____ CIGARS/DAY         | _____ PIPEFULS/DAY       |                          |  |                          |                          |                          |

## **PRIVACY ACT STATEMENT**

Under Title 5 USC 552a(e)(3), the following information is provided to you when supplying personal information to the U.S. Coast Guard.

1. AUTHORITY WHICH AUTHORIZED THE SOLICITATION OF THE INFORMATION: Occupational Safety Act of 29 December 1970, P.L. 91-596, 91st Congress S-2193.
2. PRINCIPAL PURPOSE(S) FOR WHICH THE INFORMATION IS INTENDED TO BE USED: To collect and monitor occupational safety and health hazards exposures of Coast Guard civilian and military personnel.
3. THE ROUTINE USES WHICH MAY BE MADE OF THE INFORMATION: To provide health care to affected personnel and to establish a data base of information for the enhancement of the physical environment.
4. DISCLOSURE OF THE INFORMATION IS MANDATORY AND THE EFFECTS ON THE INDIVIDUALS, IF ANY, OF NOT PROVIDING ALL OR ANY PART OF THE REQUESTED INFORMATION: It could result in incomplete or insufficient health care for the individual(s) and could prevent the removal or correction of existing hazard, due to incomplete or inadequate information.